PRINTED: 09/04/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		Δ RIII	LDING	01	COMPL	ETED	
		155790	B. WIN			08/10/	2012
			D. 1111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					CAREY RD		
KINDRED TRANSITIONAL CARE AND REHAB-BRIDGEWATI					EL, IN 46033		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0000							
	A Life Safety C	Code Recertification, State	K0	000			
	Licensure and (Quality Assurance					
	Walk-thru Surv	rey were conducted by the					
		repartment of Health in					
		h 42 CFR 483.70(a).					
	accordance with	11 +2 C1 K +03.70(a).					
	Survey Date: 0	08/10/12					
	Survey Date: 0	76/10/12					
	Facility Numbe	er: 012548					
	Provider Numb						
	AIM Number:						
	Alivi Nullibei.	201023700					
	 Survevor: Mari	k Caraher, Life Safety					
	Code Specialist	•					
	Code Specialist	•					
	At this Life Saf	ety Code survey, Kindred					
		re and Rehab-Bridgewater					
		n compliance with					
		or Participation in					
	_	-					
		caid, 42 CFR Subpart					
		Safety from Fire and the					
		f the National Fire					
	Protection Asso	ociation (NFPA) 101, Life					
	Safety Code (L	SC), Chapter 18, New					
		cupancies and 410 IAC					
	16.2.	•					
	This one story f	facility was determined to					
	1	(11) construction and fully					
		-					
	_	ne facility has a fire alarm					
	_	oke detection in the					
	corridors and in	all areas open to the					
	I		ı				I

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

PW6L21

012548

Facility ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BU	ILDING	01	COMPLETED	
		155790	B. WI	NG		08/10/2012
NAME OF E	PROVIDER OR SUPPLIE	TR.		STREET A	DDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER					CAREY RD	
KINDREI	D TRANSITIONAL	CARE AND REHAB-BRIDGEWA	TER	CARME	L, IN 46033	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		acility has smoke detectors				
	hard wired to the	ne fire alarm system in all				
	_	g rooms. The facility has				
	a capacity of 12	20 and had a census of 90				
	at the time of th	is visit.				
		s found in compliance with				
	_	ard to sprinkler coverage				
	and smoke dete	ctor coverage.				
	All areas where	residents have customary				
	access were spr	inklered. The facility has				
	one detached by	ailding providing facility				
	services includi	ng the generator transfer				
	switch and med	ical gas storage which was				
	not sprinklered.	_				
	1					
		Robert Booher, Life Safety				
	Code Specialist-M	edical Surveyor on 08/13/12.				
	TD1 6 11:	6 1				
	_	s found not in compliance				
		entioned regulatory				
	^	evidenced by the				
	following:					

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Event ID: PW6L21

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PRINTED: 09/04/2012 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-BRIDGEWATER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (COSS-REFERENCED TO THE APPROPRIATE DATE) K0038 NFPA 101				(X3) DATE SURV COMPLETED	3) DATE SURVEY			
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-BRIDGEWATER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) K0038 NFPA 101 STREET ADDRESS, CITY, STATE, ZIP CODE 14751 CAREY RD CARMEL, IN 46033 (X5) PREFIX (EACH OF DEFICIENCY MUST BE PERCEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE) COMPLETION DATE	AND PLAN	OF CORRECTION		A. BUI	LDING	01		
KINDRED TRANSITIONAL CARE AND REHAB-BRIDGEWATER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (K0038 NFPA 101			155790	B. WIN			08/10/2012	
KINDRED TRANSITIONAL CARE AND REHAB-BRIDGEWATER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) K0038 NFPA 101 CARMEL, IN 46033 (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE COMPLETION TAG TAG OFFICIENCY DATE	NAME OF PROVIDER OR SUPPLIER							
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) K0038 NFPA 101 (X5) COMPLETION DEFICIENCY) DATE	KINDREI	TRANSITIONAL (CARE AND REHAR-BRIDGEWAT					
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K0038 NFPA 101 TAG DEFICIENCY COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE				1		1		
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE K0038 NFPA 101						PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
K0038 NFPA 101		`						
SS=F LIFE SAFETY CODE STANDARD	SS=F		DDE STANDARD					
Exit access is arranged so that exits are			•					
readily accessible at all times in accordance with section 7.1. 18.2.1								
Based on observation and interview, the K0038 This serves as the Allegation of 08/27/2012				K00)38	This serves as the Allegation	of 08	/27/2012
facility failed to ensure 10 of 11 exit door Compliance for Kindred						Compliance for Kindred		
electromagnetic locks remained unlocked Transitional Care &		1 -					the	
while the fire alarm was activated. LSC Rehabilitation-Bridgewater for the recent complaint survey dated		while the fire ala	arm was activated. LSC					
18.2.1 requires every aisle, passageway, 8/10/2012.		18.2.1 requires e	every aisle, passageway,					
corridor, exit discharge, exit location, and Kindred-Bridgewater asserts that	corridor, exit discharge, exit location, and					_		
access to be in accordance with Chapter all corrections described on this			_			all corrections described on this Plan of Correction have been implemented. In regards to the specific deficiencies, we have		
Plan of Correction have been		7. LSC 7.2.1.6(a) requires doors with special locking arrangements such as						
electromagnetic locks to unlock upon outlined our corrective actions		^ ~	· ·			outlined our corrective actions	;	
actuation of an approved fire alarm and continued interventions to			•)	
system installed in accordance with LSC assure compliance with regulations and our plan of action.							tion	
regulations and our plant of detion.		·				The staff of Kindred-Bridgewater is committed to delivering high		
·			•					
the facility quality health care to its residents			\mathcal{E}					
to obtain their nighest level of		,				to obtain their highest level of physical, mental, and		
		Findings include	: :			psychosocial functioning. We		
respectfully submit		Based on observations with the Maintenance Director during a tour of the facility from 12:10 p.m. to 3:00 p.m. on 08/10/12, the electromagnetic locks on all facility exits, except for the main						
Based on observations with the Kindred-Bridgewater is in						_		
Maintenance Director during a tour of the substantial compliance as set forth below, we are confident that						•		
facility from 12:10 p.m. to 3:00 p.m. on it will be found in substantial							,riat	
						compliance with regulations upon re-survey. The statements made on the plan		
facility exits, except for the main								
entrance, did not release and remain The statements made on the plan of correction are not an								
unlocked when the fire alarm was admission to and do not								
activated at 2:19 p.m. Based on interview constitute an agreement with the		activated at 2:19	p.m. Based on interview				the	
at the time of the observations, the alleged deficiencies herein.			_			alleged deficiencies herein.		
Maintenance Director stated the main		Maintenance Director stated the main						
entrance is locked overnight and The facility provides exit access						The facility provides ovit access		
acknowledged the electromagnetic locks arranged so that exits are readily			-			* *		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/04/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155790	A. BUILDING B. WING	01 	COMPLETED 08/10/2012
	ROVIDER OR SUPPLIER	CARE AND REHAB-BRIDGEWATE	147	EET ADDRESS, CITY, STATE, ZIP CODE 151 CAREY RD RMEL, IN 46033	•
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	CROSS-REFERENCED TO THE APPROP	BE COMPLETION
	<u> </u>	its, except for the main release and remain he fire alarm was		accordance with section 7.1. The exit door electromagnets are locks release when the fire	gnetic
	3.1-19(b)			is activated. 2. The facility only has the fire alarm system and is maintained by the Maintena Director and by an outside through quarterly checks. A outside vendor replaced the relay module that caused the malfunction of the exit door 3. An LED on the power subox that supplies power to relay module lights red whe functioning properly. A bacrelay is onsite in case of fut failure. 4. Monitoring by the Mainte Director or designee will ocweekly during Life Safety roand be reported through the Safety committee to the Performance Improvement committee. 5. Completion date will be 8/27/12.	one ance vendor An e faulty ne locks apply the in it is kup ure enance cur bunds

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